Care Quality Commission

Pages Homes Limited

Ash Grove Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Ash Grove Care Home is a residential care home providing regulated activities to up to 30 people. The service provides support to people living with dementia and a range of other health needs for example, diabetes, epilepsy and people needing support with mobility. At the time of our inspection there were 26 people using the service.

People's experience of using this service and what we found
People lived safely and were protected from the risk of harm and abuse. Risk assessments were in place relevant to people's health and social care needs and people were supported by a staff team that knew them well. Staff had been recruited safely. People received their medicines from trained staff and administration was recorded appropriately and medicines stored safely. The service was clean with a team of domestic staff working 7 days each week. The registered manager shared learning with staff following accidents and incidents.

People and their loved ones met the registered manager for a thorough pre-assessment process before moving to the service. The registered manager ensured that the staff team had the right skills, training and experience to be able to manage people's needs. People were supported to keep their health and social care appointments. People's nutrition and hydration needs were met by a team of kitchen staff who knew people's dietary needs. The service had been adapted and designed to enable people to access all areas safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were treated with kindness and respect. People's privacy was respected and dignity maintained. People were encouraged to be as independent as they could be with daily tasks and activities with staff being aware of the support sometimes needed to help people achieve their goals.

Care plans were written and presented in a person centred way concentrating on what people could achieve for themselves before then describing support needs. People's communication needs were met with some needing support from staff who were aware of body language and individual signs and what they meant. Activities were available to people either in small groups or 1 to 1 every day. People and their loved ones were confident to raise complaints and told us they knew concerns raised would be addressed. People received positive end of life care by staff trained in this important area of care.

People spoke well of the registered manager who was described as being approachable, visible and supportive by people, relatives and staff. Monthly auditing of key systems and processes was carried out with any issues highlighted and acted on. Everyone had an opportunity to provide feedback about the

service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 21 March 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service and the age of the last rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Care Quality Commission

Ash Grove Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 1 inspector.

Service and service type
Ash Grove Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ash Grove Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time looking around the service and talking with people that lived there. We spoke with 7 people who lived at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 7 staff including the registered manager, deputy manager, chef, activities lead and 3 care staff. We spoke with 1 professional and 1 relative.

We looked at a range of documents including 5 care plans and associated documents relating to risk management. We looked at Medicine Administration Records (MAR), auditing and quality assurance processes and examined 4 staff personnel files. We looked at documents relating to accidents and incidents, training and safeguarding.

After the inspection new talked to a further 3 relatives and contacted 3 professionals who visit the service.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
● People were safe and protected form the risk of harm and abuse. Safeguarding and whistleblowing systems and policies were in place and staff had received training and knew what action to take if they suspected abuse. Whistleblowing allows staff to raise concerns anonymously and staff told us they were confident to use this process if needed.
● Staff told us what they would do if they witnessed a safeguarding incident. A staff member told us, "I'd inform the manager and record everything I'd seen." Another said, "I'd make safe and talk through the steps to take. I know I can approach CQC and adult social care if I need to."
● People told us they felt safe. Comments from people included, "I feel safe here" and "I like it here because it's safe." Similarly, relatives told us, "It's safe. They look after her so well" and "Staff are so kind, they support people safely."
● The registered manager kept records of all incidents where safeguarding issues were suspected. All incidents were discussed with the local authority and clear audit trails of communications were recorded, including outcomes where incidents were further referred to the CQC. Any learning from safeguarding incidents was shared with staff.

Assessing risk, safety monitoring and management
● Risks relevant to people had been identified, assessed, and recorded. Each care plan contained risk assessments which were reviewed monthly and more frequently following incidents or changes in people's circumstances. We saw risk assessments in place for people living with an increased risk of falling, people living with diabetes, dementia, and epilepsy.
● Sections within care plans each had a rating according to the likelihood of the person being at risk. A red rating indicated the highest potential risk for example, people who had experienced several falls. This was clearly highlighted and there was guidance for staff to follow for example, making sure people had appropriate footwear, staff to be present during all moving and handling and regular reviews of medicines given. An amber rating indicated a medium risk and a green rating a minimal risk.
● People living with vulnerable skin who were at risk from soreness were supported with regular assessments using a recognised tool, the Waterlow assessment. This measured people's weight and BMI scores and any changes that might increase the risk of pressure sores developing were recorded and advice sought from other professionals, for example, District Nurses, when needed.
● Personal emergency evacuation plans (PEEPs) were in place with a copy kept in an emergency grab bag at the front of the service. Safety documents relating to fire assessments and checks on equipment were in place. Certificates were in place showing regular testing for the service lift, electric equipment and legionella testing.

Staffing and recruitment

● Enough staff were employed at the service to ensure people's care and support needs were met. We observed staff in all parts of the service throughout our inspection always being available to help people. Call bells were consistently answered within a few seconds. Shift rotas confirmed that there were enough staff on duty for every shift.

● There were staff in support roles that worked at the service 7 days a week. There were a team of 3 domestic staff, 3 staff responsible for activities and 3 staff working in the kitchen.

● Staff were recruited safely with all of the necessary safety checks being carried out before new staff started working at the service. We looked at 4 staff files and each contained references, photographic identification, interview notes and signed job contracts. Every staff member had an in date Disclosure and Barring Service (DBS) check. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● Medicines were administered safely by trained staff. Staff had regular competency checks and the registered manager carried out 'spot' checks, unannounced supervision of staff practice.

● During medicine rounds medicines were measured out for each person. The medicine trolly was locked in between and the staff member then recorded medicines given on the medication administration record (MAR). Entries were signed, dated and a running count of remaining medicines was completed.

● Staff responsible for administering medicines were able to tell us the steps they took if a person refused to take their medicines. A staff member told us, "Refusals are rare and I'd always try again or get another trained staff member to try. If though they refuse 3 times then I'd call the GP."

● A protocol was in place for administering 'as required,' PRN medicines, for example, pain relief. These were clearly marked on MAR charts with a process in place if non prescribed PRN medicines were frequently requested.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

There were no restrictions on relatives and loved ones visiting the service. Government guidelines had been followed during the recent Covid 19 pandemic and relatives told us they knew their loved ones were safe and were able to communicate through regular phone calls and using video messaging technology.

Learning lessons when things go wrong

● Accidents and incidents and details of action taken had been recorded. Copies were kept with care plans and in a separate file to enable the registered manager to audit records for any trends or patterns.

● Records showed what steps had been taken to minimise the recurrence of accidents and incidents. This

involved for example, increased staff presence and more frequent checks on people who had experienced a fall.

● The registered manager looked at reports and any identified learning and opportunities to make people safer, were shared with all staff.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The registered manager or deputy manager carried out a thorough pre-assessment process for anyone wanting to move to the home. Most referrals were made from the local authority and on receipt of the initial care plan notes, managers would assess to ensure they could provide the best environment to support people.
● Pre-assessment meetings were arranged with people and their families to discuss in detail people's care and support needs. Managers would ensure they had the staff with the right training to be able to support people. The registered manager told us, "Sometimes there are small gaps in training but this is rectified before anyone moves."
● Relatives confirmed they were involved in the pre-assessment process. A relative said, "It was like a getting to know you session. Very thorough, even went through food likes and dislikes." Another told us, "Someone came to the house, a very thorough process with loads and loads of questions."
● The registered manager told us that people often visited the service before moving in. After moving in they were kept under review to make sure they and their relatives were happy and that all of their care and support needs were being met. Regular reviews took place.

Staff support: induction, training, skills and experience
● Staff went through an induction when they first started working at the service. The induction process involved some classroom training sessions, familiarisation with the service and with the people living there. Staff were given opportunities to shadow more experienced staff before working alone.
● Ongoing support was given to staff through regular supervision meetings. A staff member told us, "I can ask for any extra training or support I need. Any concerns about residents or families or any problems." The registered manager's office was at the centre of the service and opened out onto a communal area. Throughout our inspection staff were seen to pop into the office to speak with managers and get advice and support as needed.
● The registered manager kept a spreadsheet of all training staff had completed and dates of refresher training. This contained a colour code that highlighted any training that was due in the next 7 days and any that was overdue. A staff member said, "The training here is good and they would support with other training if you had an interest."
● The staffing team consisted of some newer members and some staff that had worked at the service for many years. There had been changes in management in recent years but the longer serving staff provided a consistency of knowledge and care about the people living at the service.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported with their nutrition and hydration needs. A four week seasonal menu was offered to people and there were further alternatives available if needed. We saw people helping themselves to fruit, snacks and drinks throughout our inspection. Staff were present to support people that needed help.

● Daily and weekly menus were displayed in the dining area with written and pictorial representations of what was on offer. People had a choice of where to take their meals with some sitting together in the dining area and others choosing to eat in their rooms.

● The chef had a clear understanding of people's different needs. A chart in the kitchen showed who required a diabetic diet, who was vegetarian and people's likes, dislikes and allergies. We saw the chef talk with several people during our inspection, asking them if they wanted more drinks or food, appropriate to their needs.

● People told us they enjoyed the food. Comments included, "Food is excellent," "The food is very good" and "Can get food and snacks whenever I like."

● Temperature checks on equipment and food were taken and recorded daily. There was a cleaning schedule for the kitchen and the equipment and the service had received the highest hygiene rating.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support

● The registered manager worked well with other health and social care professionals and this had achieved positive outcomes for people. For example, weekly 'ward rounds' took place with a medical professional. This provided an opportunity to discuss people's current health needs and provide additional support if required. A professional told us, "The ward rounds are good and they will call us in-between for a visit if needed."

● Other professionals for example chiropodists and speech and language therapists (SALT), regularly attended the service. The registered manger made off site appointments for people when needed for example, to visit dentists or hospital visits. A relative told us, "They make appointments and always ask me if I want to be present. They've seen the doctor and visiting chiropodist and hairdresser."

● Changes to people's daily health were monitored and recorded for example people's weight, BMI, Must scores and if there were concerns, temperatures taken. All of these detail were recorded in daily notes within the care plans so changes could be seen immediately and any necessary action or support provided.

Adapting service, design, decoration to meet people's needs

● The service had a lift to enable access to all 4 floors of the service. An ongoing cycle of decorating was in progress with bedrooms being re-decorated on becoming vacant. People were able to spend time where they chose either in their rooms or in one of the communal areas.

● People were able to bring their own small items of furniture and other personal effects when they moved into the service. We saw bedrooms which contained family photographs and other items that created a homely feel to people's rooms.

● We spent time observing people in the communal areas of the service. Some people were enjoying small group activities and others chose to sit and watch television.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff supported some people to make decisions. Most people were able to make daily decisions relating to food choices, where they wanted to spend their time and what clothes they would like to wear. Staff helped people by presenting choices and options.
● Staff were aware of the importance of gaining consent from people who were unable to make decisions due to lacking mental capacity. A staff member said, "It's important to explain everything you want to achieve. If unwilling, give time, try again later." Another staff member added, "Sometimes explain why a thing should be done like personal care. If they are unsure, go away, come back again or maybe try another staff member."
● People's mental capacity had been assessed where it was suspected they needed help with specific decisions. For example, consenting to personal care and being supported with medicines. Assessments were recorded in people's care plans and were subject of regular reviews by the registered manager.
● Several people living at the service had DoLS in place. DoLS had been appropriately applied for taking into account people's best interests and were similarly subject to regular reviews.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff treated people respectfully. We observed several interactions between staff and people during our inspection and all were positive with people smiling and engaging in conversations with staff. A staff member said to a person, "Would you like your nails done? What colour? That's lovely." The person responded, "It's nice to meet you and thank you."
- Staff knew people well and responded to their needs whilst engaging in friendly conversations. Staff called people by their preferred names. We saw staff in support roles for example, the domestic staff and the chef, talking to people as they carried out their roles. There was a family atmosphere within the service.
- People's equality characteristics were discussed and respected. Differences and any cultural or faith wishes were recorded in car plans. A staff member said, "We treat everyone as they want to be treated."

Supporting people to express their views and be involved in making decisions about their care

- During the pre-assessment meeting people's preferences about how they wanted to receive care and support were discussed. Preferences about being supported by male or female carers, how and where they liked to spend their day and whether or not they wanted to take part in group or 1 to 1 activities were all recorded.
- People were offered choices each day and their decisions were respected. Daily notes provided a timeline of events and activities people had been involved in. These notes showed incoming staff how people had been spending their time and what support had been provided and gave an indication of how people were feeling and what further support was needed.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was respected. We saw staff knock on people's bedroom doors and wait for a response before entering. People were able to spend time in their rooms whenever they wanted to. Personal information was held on password protected computer systems with any paperwork stored in locked cupboards within a locked office. Staff handover meetings, where people's daily care and support were discussed among staff, were held in a quiet area away from people and visitors.
- People's dignity was upheld and staff treated people with respect. A relative told us that their loved one had taken time to settle in to the service and frequently started to pack their bags. Staff would carefully unpack for them each time talking with them in a gentle and supportive way.
- We observed in a communal area a person who required the support of a mechanical hoist to move from an armchair to a wheelchair. They were supported by staff who put up a screen around the person so others

could not see the move being made.
● People's independence was encouraged and promoted without safety being compromised. Most people needed support with daily tasks but were encouraged by staff to do as much for themselves as possible within a safe environment with staff present. For example, brushing teeth, changing clothing and moving independently around the service using walking aids or some support from staff. A staff member said, "Independence is important, we definitely encourage it."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● Care plans were held on a computer system and were person centred. The opening page of each care plan provided a personal history of people and details of important aspects of their life and history before they moved to the service. Important health and social information was clearly displayed and recorded in a way that emphasised what people could do for themselves before describing where support was needed.
● People's preferred daily routines including where they preferred to spend their time at certain times of the day were respected and noted by staff.
● Staff updated daily notes on smaller electronic devices. These notes were added in real time and were accessible to all staff. The devices allowed staff to update and send important messages relating to care for example, if a person refused their medicines. The device then confirmed when other staff had read the message. This process enabled the registered manager to have immediate oversight of all care provision and any issues or concerns that may arise.
● Staff handover meetings were held at each shift change to update incoming staff of any issues. A staff member said, "Handovers are useful but the (electronic devices) are good for immediate alerts."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs had been met. Most people living at the service were able to communicate verbally with little support needed. Some people living with dementia needed more time to process things being said and to then respond. Staff were aware of people's needs and we saw several interactions where staff spent time with people, making sure that requests and choices were understood.
● However, some people required further support, some people were not able to communicate verbally. This information was recorded in care plans with detailed assessments in place, reviewing people's needs. For example, people could communicate using gestures and staff knew how to interpret people's body language to help them understand what was being communicated.
● The registered manager told us that some people preferred to see things either in pictorial form or in larger print. An example was the daily food menu which was displayed on the wall in the dining area both in words and in picture form to support people to understand what food was being offered that day. Daily

activities were displayed in a similar way. Larger printed posters and documents were made available when needed.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- 3 activities co-ordinators provided support to people across 7 days every week. People were offered daily choices of activities which we observed in a communal area of the service. Small group activities for example quizzes and craft activities were offered as well as individual past times such as drawing and completing puzzles. People who chose to spend time in their rooms were offered 1 to 1 activities and there were enough staff available to provide this daily.
- People and relatives told us there were plenty of things to do that interested them. A person said, "There is always something to do." A relative added, "There are activities all of the time. They've made bird boxes, go out on trips a lot. They have even got (relative) knitting again, they've not done that for a long time."
- Care plans provided details of how people liked to spend their time and the things that interested them. We observed several activities and interactions between people and activities staff. People were supported by staff who knew then well, were patient and spoke with them in a friendly and supportive way.
- The registered manager had completed monthly audits of activities to make sure that activities were still relevant to people and supported their daily lifestyle choices.

Improving care quality in response to complaints or concerns

- Complaints had been dealt with in a timely, appropriate way. The service had received very few complaints, but records were kept which showed the actions of the registered manager and the communication exchange between the service and complainants. If there were any learning points from complaints these were shared with staff.
- A complaints policy was in place which was easily accessible to people and relatives. The policy was reviewed regularly by the registered manager and we saw that complaints had been addressed within the timeframes drawn up in the policy.
- People and their loved ones told us they knew how to complain and raise issues if required and were confident that matters would be addressed by managers. A relative said, "I did raise an issue about their clothes getting mixed up with other people's. They were on the case straight away and sorted it for us." Another added, "If ever I had a complaint or issue I'd go to the manager or deputy. They are all very approachable."

End of life care and support

- People were supported at the end of their lives by staff trained in end of life care. A staff member told us, "Continue to support their needs and preferences and make them comfortable. It's important to consider the wishes of relatives and accommodate visits as often as they want."
- Decisions about end of life care were considered at pre-assessment and recorded in care plans. Key contacts were listed on the front page of care plans of who people wanted alerted in the event of declining health.
- The registered manager had developed positive working relationships with other statutory partners who could be contacted for support and advice if a person was entering the final stages of their lives. These include paramedic practitioners, community nurses and GP's.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager had been in post for less than 6 months at the time of our inspection, but in that time had created a positive culture at the service. There was a homely atmosphere that was embraced by all staff. We saw staff chatting to people, supporting them in a friendly manner often laughing and smiling with them. People and their loved ones told us it was like living at home. A relative said, "She is always happy to go back after a visit with us. This says a lot about the home."
- Everyone provided positive feedback about the registered manager. A person said, "She is excellent." A relative told us, "The home has improved so much since (registered manager) took over.
- Similarly, staff told us of a positive relationship between them and the registered manager. Comments from staff included, "Very supportive, any problems, can go to them" and "It's well run. The manager is amazing."
- The registered manager carried out monthly reviews on care plans to make sure no changes were needed to support people in the best way possible. The registered manager and wider staffing team created positive outcomes for people. A professional commented, "I tend to go mid afternoon and I see so many activities going on. Also lots of friends and relatives sitting around drinking tea and chatting."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood their responsibilities under the duty of candour which is their legal obligation to inform the local authority and CQC of certain significant events that happen at their service. This obligation had been met.
- Both the registered manager and deputy manager were honest and open with us during the inspection and responded quickly to any questions or issues that we raised. The registered manager demonstrated a willingness to improve the service and provide the best possible outcomes for people based on experience and learning.
- Information relating to the CQC was on display at the entrance to the service. This included registration details and a copy of the most recent CQC inspection report. A link to this report was also accessible from the service website homepage.

Managers and staff being clear about their roles, and understanding quality performance, risks and

regulatory requirements
● The registered manager had oversight of a robust monthly auditing process. All key areas were looked at including, care plans, medicines, infection prevention and control, kitchen and health and safety processes.
● Audits highlighted any issues and created action points that were then addressed. For example, the cleaning and environment audit that took place a month before the inspection had identified a localised unpleasant smell in a corridor that prompted an immediate deep clean and some boxes that needed clearing from a communal area, which again was immediately addressed.
● A recent audit into the possible cause of people experiencing falls had prompted some focussed learning for staff to look closely at possible causes including trip hazards and footwear worn at the time. A recent medicines audit had highlighted an administration of a PRN medicine that was not given in line with the protocol. These issues were quickly identified and rectified.
● Staff were assigned tasks at the beginning of their shifts and used electronic devices to record the actions and support they had provided. The registered manager had immediate oversight of daily records and could see for example, if a task had not been completed. This led to immediate enquiry as to the reasons why and any necessary action was then taken in people's best interests.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives told us they had opportunities to provide feedback about the service. The registered manager and deputy manager were a visible presence at the service and people had daily opportunities to speak to them and raise concerns or suggestions. Formally, there was a 'resident and family survey,' a questionnaire sent out every few months and completed by people and their relatives. Views were sought about all aspects of the service and asked for any suggestions about improvements.
● There were face to face meetings for relatives where again, issues and ideas about the service could be raised. A relative told us, "I think the meetings are quarterly. I can't get to everyone, but they send out asking what we think and any improvements or changes needed." Another relative added, "The comms (communications) are very good. They always speak to us or send e-mails."
● Similarly, staff had a variety of ways to provide feedback about the service. This could be done through various meetings, daily handovers, staff, or supervisors meetings. Also, through daily interactions with managers and more formally at supervision meetings.
● 8 recent complements had been received by the service via e-mail, letters and cards, from relatives, thanking staff for the care provided to their loved ones. Each highlighted the high quality of care and support given by the registered manager and their team.
● People's equality characteristics and differences based on their personal or cultural beliefs or wishes were recorded and respected. For example, some people had religious beliefs and they were given time to follow their faith and were supported by staff to do this. A staff member told us how they made sure a person had their rosary beads, an important part of their faith, with them towards the end of their lives.

Continuous learning and improving care
● The registered manager had a 'continuous quality improvement plan' in place that was reviewed and updated every 6 months. The plan considered key areas of the service where short to mid term improvements could be made for example, a re-decorating timeline, staffing numbers reviewed and maintained and constant improvements to care plans
● The registered manager was quite new in post but had worked for the provider for much longer. They kept themselves up to date with developments and changes in health and social care and read local authority and CQC bulletins and liaised with other managers for advice and support when needed.

Working in partnership with others

- Positive working relationships had been established with other health and social care professionals. This resulted in the best care and support possible for people with any issues arising being immediately addressed.
- professionals spoke well of the working relationship they had developed with the registered manager and the service. A professional told us, "I've always found them (managers) friendly, kind and caring towards everyone." The professional added, "If there is ever a time I've needed to know something I am informed and we chat to see what the best resolution could be."